State of New Jersey
Department of Labor and Workforce Development
Division of Workers' Compensation
PO Box 381
Trenton, New Jersey 08625-0381

EMPLOYEE'S CLAIM PETITION

(DO NOT FILL IN)

CASE No. _____

D.O. _____

PETITIONER

SOCIAL SECURITY NUMBER

NAME

ADDRESS (Including County)

ZIP CODE

VS

RESPONDENT

NAME

ADDRESS (including County)

ZIP CODE

ATTORNEY FOR PETITIONER

❑ NEW JERSEY REGISTRATION NUMBER ❑ SSN ❑ FEDERAL EMPLOYER ID NUMBER

NAME

ADDRESS

TELEPHONE (Area Code)

INSURANCE CARRIER

NAME (indicate if Not Covered or self-insured)

ADDRESS

ZIP CODE

CARRIER'S CLAIM FILE NUMBER

TO THE DIVISION OF WORKERS' COMPENSATION:

Petitioner, alleging that Petitioner sustained an injury by an accident arising out of and in the course of petitioner's employment with Respondent, compensable under R.S. 34:15-7 et seq., supplements and amendments, respectfully states:

Date of Accident ❑ Occupational Exposure Dates of Exposure	Where

How Injury Occurred

Occupation	Date Stopped Work	Date Returned to Work

Sex	Date of Birth	Date Injury Reported To Employer and To Whom

Gross Weekly Wages	Rate of Compensation	Temporary Disability Paid	Permanent Disability Paid
$	$	$	$

DESCRIBE EXTENT AND CHARACTER OF INJURY: If there has been amputation or disability to any member or impairment of any physical function, explain fully _____

Medical aid (WAS) (WAS NOT) furnished by Petitioner's employer.
Give names and addresses of physicians and hospitals:

❑ Demand is hereby made for answers to standard occupational disease interrogatories.

❑ Demand is hereby made for all records of medical treatment, examinations and diagnostic studies.

WERE YOU ELIGIBLE FOR MEDICAID BENEFITS AT THE TIME OF THE ACCIDENT? ❑ YES ❑ NO
DID YOU BECOME ELIGIBLE FOR MEDICAID BENEFITS AFTER THE ACCIDENT? ❑ YES ❑ NO
YOU ARE ADVISED THAT MEDICAID PAYMENTS RELATED TO THE ACCIDENT ARE TO BE REPAID IN ACCORDANCE WITH N.J.S.A. 30:4D-1, ET SEQ.

What other facts are there that you believe important?

In occupational disease claims, list claims against other employers filed or to be filed for the same or similar occupational diseases.

NAME & ADDRESS OF EMPLOYER	DATES OF EMPLOYMENT

Your Petitioner therefore requests that the Division of Workers' Compensation determine the amount of compensation due your Petitioner from said Respondent, under Revised Statutes of New Jersey, Title 34, Chapter 15, and the Acts supplemental thereto and amendatory thereof, and that your Petitioner may be awarded Petitioner's costs in this proceeding, and such other or further relief as may be proper.

_____

(Petitioner)

STATE OF NEW JERSEY
COUNTY OF

Subscribed and sworn or affirmed
to before me this day of
, 20

_____

This Claim Petition has been presented by the Petitioner to the Division of Workers' Compensation for hearing and determination. Unless an Answer is filed within 30 days of the date of service of the Claim Petition upon you, with the assignment clerk at the office to which the claim is assigned as indicated on the reverse side, and a copy served upon the Petitioner's attorney, THE PETITIONER WILL PROCEED WITH PROOF OF CLAIM ACCORDING TO LAW AND MAY OBTAIN JUDGMENT AGAINST YOU.

The Privacy Act, 5 U.S.C. § 552a, the Social Security Act, 42 U.S.C. § 405, and *N.J.S.A.* 34:15-1 *et seq.* authorize the Division of Workers' Compensation to request that the Petitioner supply the Division with his or her Social Security number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.

DIVISION OF WORKERS' COMPENSATION